**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TEXAS 77029

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

**Respondent Name**
TRAVELERS INDEMNITY CO

**Carrier's Austin Representative Box**
Box Number 05

**MFDR Date Received**
August 2, 2010

**MFDR Tracking Number**
M4-10-4903-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Our facility has sent two status request and request for reconsideration, all of which have not been replied to. Therefore does not give us an avenue to properly seek reimbursement for services we provided. This is also in violation of Rule 133.304 (a). The request for reconsideration and this MDR are being filed in order to comply with the requirements of RULE §133.250(B) and RULE §133.305."

**Amount in Dispute:** $56.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Provider is not entitled to reimbursement as the services performed required preauthorization which the Provider failed to obtain prior to rendering them. Under the ODG Treatment Guidelines, chiropractic manipulations this late in the treatment exceed the ODG recommendations. They consequently require preauthorization under Rule 134.600 (p)(12). Although the Provider obtained preauthorization for physical therapy, this is a different class of services, as documented by the CPT index for physical therapy codes. This index does not include CPT code 98940, the service at tissue in this dispute. As the Provider did not have preauthorization for chiropractic manipulations, and the preauthorization was required since the treatment exceeded the ODG Treatment Guidelines, the Carrier properly denied the disputed services for lack of required preauthorization."

**Response Submitted by:** Travelers

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 22, 2010 | 98940 | $56.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the preauthorization guidelines.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 165 – Payment denied/reduced for absence of, or exceeded referral

**Issues**

1. What is the definition of Physical Medicine and Rehabilitation Therapeutic Procedures?
2. What is the definition of Chiropractic Manipulative Treatment Procedures?
3. Did the requestor obtain preauthorization for CPT code 98940?
4. Is the requestor entitled to reimbursement?

**Findings**

1. The AMA CPT® Section Guidelines defines Physical Medicine and Rehabilitation Therapeutic Procedures 97110-97546 A manner of effecting change through the application of clinical skills and/or services that attempt to improve function. Physician or other qualified health care professional (ie, therapist) required to have direct (one-on-one) patient contact.
2. The AMA CPT® Section Guidelines defines Chiropractic Manipulative Treatment Procedures with code set range 98940-98943 as Chiropractic manipulative treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.
   - The requestor billed and seeks reimbursement for CPT code 98940 defined by AMA CPT® as "Chiropractic manipulative treatment (CMT); spinal, 1-2 regions."
3. Per 28 Texas Administrative Code §134.600 (p)(12), "(p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)..."
   - The insurance carrier authorized physical therapy lumbar spine 1x2 with a start date of July 21, 2009 and an end date of August 21, 2009, under preauthorization number 00006 A6J6732.
   - The requestor disputes non-payment of CPT code 98940 for date of service January 22, 2010. Review of box 23 of the CMS1500 documents preauthorization number 00006A6J6732. The requestor submitted insufficient documentation to support that CPT code 98940 was preauthorized per 28 Texas Administrative Code §134.600.
4. As a result, the requestor exceeded the preauthorization times and reimbursement cannot be recommended for CPT code 98940.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| | | |
|---|---|---|
| | | July 26, 2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.